ARTICLE 26
Group Insurances

New hires will be permitted to enroll in group insurance plans for which they are eligible during their first thirty-one (31) days of employment. Eligibility for coverage under such plans is the first day of the biweekly pay period after enrollment, except for life insurance which shall be effective on the first day of employment.

Section 1. The State Health Plan.
Effective January 1, 2003, the existing Basic and Major Medical Plan (State Health Plan Advantage) shall be replaced with the PPO plan which shall be known as the "State Health Plan". State Health Plan in-network and out-of-network benefits and applicable deductibles and co-payments are outlined in Appendix G. The Rules for Network Use are outlined in Appendix F.

A. <u>Premium Splits</u>: Except as provided in Section 10 below, the employer shall pay 95% of the premium, and the enrolled employee shall pay 5% of the premium for the State Health Plan.

Effective October 1, 2008, except as provided in Section 10 below, the employer shall pay 90% of the premium, and the enrolled employee shall pay 10% of the premium for the State Health Plan.

B. <u>Co-pay</u>: Applicable co-payments for in-network and out-of-network services under the State Health Plan are set forth in Appendix G.

Effective October 1, 2008, there will be a $15 co-pay for an office visit, and a $50 co-pay for emergency room visits if the patient is not admitted to the hospital. All other applicable co-payments for in-network and out-of-network services under the State Health Plan are set forth in Appendix G.

C. <u>Deductibles and Out of Pocket Maximums for the State Health Plan</u>: The deductibles under the State Health Plan shall be $200/individual and $400 /family per calendar year for in-network services and $500/individual and $1,000/family per calendar year for out-of-network services.

Effective January 1, 2009 the deductibles under the State Health Plan shall be $300/individual and $600/family per calendar year for in-network services and $600/individual and $1,200/family per calendar year for out-of-network services.

The maximum out of pocket cost per individual shall be $1,000 and $2,000/family per calendar year for in-network services and $2,000/individual and $4,000/family per calendar year for out-of-network services. The deductible does not apply towards the maximum out of pocket cost.

Section 2. State Health Plan Provisions.

A. The Union shall continue to be entitled to participate as a member of the Labor Management Health Care Committee. The Committee will continue to review and monitor the progress of the actual implementation of the State Health Plan. It is understood that each exclusively recognized employee organization will be entitled to designate one (1) representative to participate in the Labor Management Health Care Committee.

The Plan consists of the following principal components: pre-certification of all hospital inpatient admissions; second surgical opinion; home health care; and alternative delivery systems.

(1) Pre-certification of Hospital Admission & Length of Stay. The pre-certification for admission and length of stay component of the Plan requires that the attending physician submit to the third party administrator (TPA) the diagnosis, plan of treatment and expected duration of admission. If the admission is not an emergency, the submission must be made by the attending physician and the review and approval granted by the TPA prior to admitting the covered individual into the acute care facility. If the admission occurs as an emergency, the attending physician is required to notify the TPA by telephone with the same information on the next regular working day after the admission occurs. If the admission is for a maternity delivery, advance approval for admission will not be required; however, the admitting physician must notify the TPA before the expected admission date to obtain the length-of-stay approval. There will be no limitation on benefits caused by the attending physician's failure to obtain pre-admission certification.

(2) Second Surgical Opinion. An individual covered under the State Health Plan will be entitled to a second surgical opinion. If that opinion conflicts with the first opinion the individual will be entitled to a voluntary third surgical opinion. Second and third surgical opinions shall be subject to a $10 in-network office call fee or covered at 90% after the deductible if obtained out-of-network.

Effective 10-1-08, second and third surgical opinions shall be subject to a $15 in-network office call fee or covered at 90% after the deductible if obtained out-of-network.

(3) Home Health Care. A program of home health care and home care services to reduce the length of hospital stay and admissions shall also be available at the employee's option. This component requires that the attending physician contact the third party administrator to authorize home health care service in lieu of a hospital admission or a continuation of a hospital confinement.

The attending physician must certify that the proper treatment of the disease or injury would require continued confinement as a resident inpatient in a hospital in the absence of the services and supplies provided as a part of the home health care plan. If appropriate, certification will be granted for an estimated number of visits within a specified period of time. The details of the types of services and charges that shall be covered under this component include part-time or intermittent nursing care by a registered nurse (R.N.) or licensed practical nurse if an R.N. was not available; part-time or intermittent home health aid services; physical, occupational and speech therapy; medical supplies, drugs and medicines prescribed by a physician, and laboratory services provided by or on behalf of a hospital, but only to the extent that they would have been covered if the individual had remained or been confined in the hospital. Home health care services under the SHP will be continued. Details of the covered services will be provided in the SHP benefit booklet. Home health care shall be available at the patient's option in lieu of hospital confinement. To receive home health care services, a patient shall not be required to be homebound. Home infusion therapy shall be covered as part of the home health care benefit or covered by its separate components (e.g. durable medical equipment and prescription drugs).

(4) Alternative Delivery Systems. The State Health Plan shall also provide hospice care and birthing center care benefits to employees and enrolled family members. To be eligible for the hospice care benefit, the covered individual must be diagnosed as terminally ill by the attending physician and/or hospice medical director with a medical prognosis of six months or less life expectancy. Covered hospice benefits include physical, occupational, and speech language therapy; home health aid services; medical supplies; and nursing care. Covered hospice benefits are not subject to the individual deductible or any co-payment and will be paid only for services rendered by federally certified or state licensed hospices. Hospice services covered under the SHP will be continued. Details of the covered service will be provided in the SHP booklet. Both hospice care and birthing center care shall be available to employees at their option in lieu of hospital confinement. Birthing center care is covered under the delivery and nursery care benefit set forth in Appendix G.

B. Prescription Drugs: Bargaining unit members who are covered by the State Health Plan will be enrolled in the alternative prescription drug PPO.. The Employer shall continue an optional mail order plan for maintenance prescription drugs. The employee co-pay shall be $7 per prescription for generic drugs and a $15 co-pay per prescription for brand name drugs for both the retail and mail order drug plans. The brand name co-payment level will apply even when there is no generic substitute, as well as to DAW prescriptions. Effective October 1, 2005, the employee co-pay for non-preferred brand name drugs will be $30.00.

Effective October 1, 2008, the plan will include the programs of: Generics

Preferred, Step Therapy and Drug Quantity Management. The employee co-pay at retail shall be $10 per prescription for generic drugs, $20 per prescription for preferred brand name drugs, and $40 for non-preferred brand name drugs. The employee co-pay for mail order shall be $20 per prescription for generic drugs, $40 per prescription for preferred brand name drugs, and $80 for non-preferred brand name drugs. The brand name co-payment level will apply even when there is no generic substitute, as well as to DAW prescriptions. Under the Generics Preferred program, a prescription marked DAW may result in an additional charge to the employee of the difference in cost between the generic and the brand name drug dispensed.

Brand name drugs determined to be non-preferred because of the availability of a generic equivalent or a therapeutically or chemically equivalent brand name drug shall be so designated by the pharmacy and therapeutics committee comprised of independent physicians across various specialties. The State of Michigan shall have no decision making authority in such determination.

Prescriptions purchased at non-participating pharmacies must be paid for by the plan member who then remits receipts to the vendor for reimbursement. The amount of the reimbursement will not exceed the amount the vendor would have paid to a participating pharmacy and will not include the applicable co-payment.

The member card shall identify all the participating pharmacies within a 30-mile distance of the plan member's home address zip code or, if there are more than 30 such participating pharmacies, the 30 participating pharmacies that are closest to the plan member's home.

Zyban and Nicotrol nasal spray for smoking cessation shall be included under the prescription drug benefit.

All maintenance drugs filled at a participating retail pharmacy will only be approved up to a 34 day supply.

C. Mental Health/Substance Abuse Services: Benefits for in-patient and out-patient mental health care and substance abuse services shall be as outlined in Appendix G.

If there is no network provider within a reasonable distance from the member's home address (as determined by the director of the Employee Benefits Division), the vendor will authorize payment for covered services which are provided by a non-network provider as permitted under the State Health Plan in effect prior to the implementation of the PPO.

The State Health Plan will maintain a system of alternative provider referrals and equivalent covered expense reimbursement which assures that, at the patient's option, network providers to whom the patient is referred are neither state employees nor providing services to a state agency at a worksite where the state employee is employed.

D. Hearing: The State's hearing care program shall continue to be a benefit under the State Health plan. Such program shall include those benefits currently provided, including audiometric exams, hearing aid evaluation tests, hearing aids and fitting and binaural hearing aids when medically appropriate subject to a $10 office call fee for the examination and shall be available once every 36 months unless hearing loss changes to the degree determined upon advice by the State Health Plan’s medical policy team and audiology professionals. Effective October 1, 2008, the office call fee shall be $15.

E. Wellness and Preventive Services: Wellness and preventive coverage in accordance with the State Health Plan as outlined in Appendix G will be subject to a maximum plan payment of $1500 for in-network services per individual per calendar year. There shall be no coverage for wellness and preventive services received out-of-network.

Effective January 1, 2006, the cost for a colonoscopy exam (one every ten years beginning at age 50), and the cost for childhood immunizations will not be applied toward the calendar year maximum. These services will be covered at 100% in-network with no deductible and out-of-network at 90% after the deductible.

F. Weight Loss: Expenses of weight-loss clinic attendance are covered up to a lifetime limit of $300, if conditions are met as specified in either (1) or (2) below:

(1) The employee or covered dependent is obese (defined as being more than 100 pounds overweight or more than 50% over ideal weight), and weight loss clinic attendance is prescribed by a licensed physician and confirmed by a second opinion; or

(2) The employee or covered dependent is more than 50 pounds overweight or more than 25% over ideal weight, has a diagnosed disease for which excess weight is a complicating factor, and weight-loss clinic attendance is prescribed by a licensed physician and confirmed by a second opinion.

Note: the $300 amount will not apply to the State Health Plan deductible.

G. Orthopedic Inserts: Medically necessary orthopedic inserts for shoes, when prescribed by a licensed physician are covered under the State Health Plan. This benefit is included under the durable medical equipment benefit in Appendix G.

H. Blood Storage: Storage costs for blood that is self-donated by an employee or covered dependent in preparation for his/her own scheduled surgery is covered by the State Health Plan subject to the individual deductible.

I. Disease Management Program: The Disease Management Program currently known as Blue Health Connection shall be included under the State Health Plan as a covered benefit on a voluntary basis.

J. Survivor Conversion Option: The State recognizes its obligations under federal "COBRA" legislation in case of a "qualifying event", as defined by that statute.

K. Health Risk Appraisal Program: The parties agree to continue extending the health risk appraisal program to bargaining unit members during the term of this Agreement.

L. Open Enrollment: There shall be an annual open enrollment period offered to unit members in July or August of each year of this Agreement.

M. Smoking Cessation/Abatement Assistance: The State shall continue a program for reimbursing employees for the fee they paid for enrolling in, and completing, a smoking cessation/abatement program approved by their appointing authority. The following conditions shall apply:

(1) The reimbursement will be available for the employee's participation only. Expenses incurred by the employee's dependents are not reimbursable, even if the employee paid part or all of them.

(2) The reimbursement shall be available on a one-time-only basis.

(3) The amount of the reimbursement shall not exceed $50.00.

(4) The employee shall be required to produce proof satisfactory to the appointing authority that the employee has completed the program, as well as receipts for having paid the enrollment fee. No reimbursement shall be required if a smoking cessation/abatement program is available to the employee through his/her health care coverage at no additional charge.

(5) This program shall not be considered a part of the State Health Plan, and reimbursements are not payable through the State Health Plan. The reimbursement shall be paid to eligible employees by the departmental employer.

Transdermal Patches: bargaining unit members shall continue to be eligible, on a one-time-only basis, for reimbursement of the cost of transdermal patches, less the $2.00 co-payment, and accompanying smoking cessation counseling not otherwise available as a covered benefit under the health plan in which the employee is enrolled. An employee who has already received reimbursement for transdermal patches under any program sponsored by the State shall not be eligible for this benefit. Reimbursement shall be made by the departmental employer.

N. Subrogation: In the event that a participant receives services that are paid by the State Health Plan (SHP), or is eligible to receive future services under the SHP, the SHP shall be subrogated to the participant's rights of recovery against, and is entitled to receive all sums recovered from, any third party who is or may be liable to the participant, whether by suit, settlement, or otherwise, to the extent of recovery for health related expenses. A participant shall take such action, furnish such information and assistance, and execute such documents as the SHP may request to facilitate enforcement of the rights of the SHP and shall take no action prejudicing the rights and interests of the SHP.

O. Reimbursement For Certain Services And Equipment: The reimbursement for in-network and out-of-network private duty nursing and acupuncture therapy shall be 90% after the deductible is met.

P. Office Visits And Consultations: Effective January 1, 2003 in-network office visits and office consultations will be subject to a $10 co-pay and will not be applied toward the individual or family deductible. Out-of-network office visits and office consultations shall be covered at 90% after the deductible is met. Effective October 1, 2008, the co-pay for office visits and office consultations shall be $15.

Q. In-Network And Out-Of-Network Access: In-network and out-of-network access is described in the Letter of Understanding and attached Rules for Network Use in Appendix F.

R. Effective October 1, 2005, in-network chiropractic spinal manipulation will be subject to a $10 co-pay and will not be subject to the deductible. Effective October 1, 2008, in-network chiropractic spinal manipulation will be subject to a $15 co-pay and will not be subject to the deductible. Out-of-network chiropractic spinal manipulation shall be covered at 90% after the deductible is met.

S. A PPO network for durable medical equipment (DME) and prosthetic and orthotics appliances will be integrated into the SHP PPO with in-network reimbursed at 100% and out-of-network reimbursed at 80% of approved charges. No deductible will be required.

Section 3. Health Maintenance Organizations (HMOs).
As an alternative to the state-sponsored health insurance program, enrollment in an HMO shall be offered to those employees residing in areas where qualified licensed HMOs are in operation. The State shall pay the same dollar value contribution toward HMO membership (per enrolled employee) as is paid to the state-sponsored health insurance program for both employee and employee/dependent coverage, except where the membership cost is less than the state-sponsored health

insurance program premium. In such case, the State shall pay that rate published by the Employee Benefits Division. If an employee moves to a new permanent residence outside the service area of the authorized HMO in which s/he is enrolled, the employee may transfer such enrollment to the State Health Plan or to another authorized HMO serving the new residence area. Effective October 1, 2008 the Employer shall pay 95% of the HMO premium up to the amount paid for the same coverage code under the State Health Plan PPO.

The parties agree to meet annually through the Labor-Management Health Care Committee to discuss HMO costs and make recommendations for changes in order to keep HMOs affordable.

Section 4. Life Insurance.
The Employer shall provide a state-sponsored group life insurance plan which has a death benefit equal to 2.0 times annual salary rounded up to the nearest $1,000. The Employer shall pay 100% of the premium for this benefit.

The employee shall pay 100% of premiums for covered dependents. There shall be no age ceiling for coverage for handicapped dependents, and such additional coverage shall be provided without increased premium cost. A dependent will be considered handicapped if he/she is unable to earn his/her own living because of mental retardation or physical handicap and depends chiefly on the employee for support and maintenance.

The employee may choose one from among five levels of dependent coverage:

- Spouse for $1,500; child(ren) for $1,000
- Spouse for $5,000; child(ren) for $2,500
- Spouse for $10,000; child(ren) for $5,000
- Spouse for $25,000; child(ren) for $10,000
- Spouse for $0; child(ren) for $10,000

Dependent coverage for children shall be limited to infants 15 days or older.

The Employer agrees to continue the line-of-duty accidental death benefit of $100,000.

Section 5. Long Term Disability Insurance.
The Employer shall maintain the existing long term disability insurance coverage, except that effective October 1, 2005, the eligibility period for Plan II claimants who remain totally disabled shall be reduced from age 70 to age 65, or for a period of 12-months, whichever is greater. Additionally, the benefit period for ”mental/nervous” claims shall be limited to 24 months from the beginning of the time a claimant is eligible to receive benefits. This limitation does not apply to mental health claims where the claimant is under in-patient care. These changes shall only apply to new claims made on or after October 1, 2005.

The Employer shall continue to provide a rider to the existing LTD insurance program. All employees who are enrolled in the LTD insurance program shall automatically be covered by this rider. The rider shall provide a waiver of 100% of the health insurance (or HMO) premium while the enrolled employee is receiving LTD insurance benefits for a maximum of six (6) months. The Employer shall pay the entire cost of such rider. To thereafter continue health insurance (or HMO) coverage during the LTD-compensable period, the employee shall be responsible for remitting his/her share of the premium (if applicable). If not prohibited by the IRS, an employee whose LTD rider has expired, may transfer immediately to a state-employee spouse's health plan.

The LTD benefit shall be payable twice monthly for the first six months of disability; after six months, benefits shall be paid monthly.

An employee may "freeze" any sick leave accrued during the period when he/she is using up sick leave because of the disability which leads directly to receiving LTD benefits.

The monthly maximum benefit will be $5000 for disabilities beginning after September 30, 2002.

Section 6. Group Dental Plans.

A. Except as provided in section 10 below, the Employer shall pay 95% of the applicable premium for employees enrolled in the State Dental Plan.

B. Benefits payable under the State Dental Plan will be as follows:

(1) 90% of actual fee or usual, customary and reasonable fee, whichever is lower, for restorative, endodontic, and periodontic services (x-rays, fillings, root canals, inlays, crowns, etc.).

(2) There shall be a yearly maximum benefit of $1,500 per person, which does not include orthodontics. For orthodontics there shall be a separate $1,500 lifetime maximum benefit.

C. Covered Dental Expenses: The State Dental Plan will pay for incurred claims for employee and/or enrolled dependents at the applicable percentage of either the actual fee or the usual, customary and reasonable fee, whichever is lower, for the dental benefits covered under the State Dental Plan for each covered person in each twelve (12) month period (fiscal year) exclusive of orthodontics for which there is a separate lifetime maximum benefit.

(1) The following services will be paid at the 100% benefit level:
Diagnostic Services:

- Oral examinations and consultations twice in a fiscal year.
- Effective October 1, 2005, oral exfoliative cytology (brush biopsy) will be covered when warranted from a visual and tactile examination.

Preventive Services:
Prophylaxis - teeth cleaning three times in a fiscal year.

Topical application of fluoride for children up to age 19, twice in a fiscal year. Space maintainers for children up to age 14, unless an older age is specifically authorized by the dental plan administrator.

(2) The following services will be paid at the 90% benefit level:

Radiographs:

Bite-wing x-rays once in a fiscal year unless special need is shown to the satisfaction of the dental plan administrator.

Full mouth x-rays once in a 5 year period unless special need is shown to the satisfaction of the dental plan administrator.

Restorative Services:

Amalgam, silicate, acrylic, porcelain, plastic and composite restorations.

Gold inlay and outlay restorations.

Oral Surgery:

Extractions, including those provided in conjunction with orthodontic services.

Cutting procedures.

Treatment of fractures and dislocation of the jaw.
Endodontic Services:

Root canal therapy.

Pulpotomy and pulpectomy services for partial and complete removal of the pulp of the tooth.

Periapical services to treat the root of the tooth.

Periodontic Services:
Periodontal surgery to remove diseased gum tissue surrounding the tooth.

Adjunctive periodontal services, including provisional splinting to stabilize teeth, occlusal adjustments to correct the biting surface of a tooth and periodontal scaling to remove tartar from the root of the tooth.

Treatment of gingivitis and periodontitis diseases of the gums and gum tissue.

(3) The following prosthodontic services will be paid at the <u>50% benefit level</u>:

Repair or rebasing of an existing full or partial denture.

Initial installation of fixed bridgework.

Initial installation of partial or full removable dentures (including adjustments for 6 months following installation).

Construction and replacement of dentures and bridges (replacement of existing dentures or bridges is payable when 5 years or more have elapsed since the date of the initial installation).

(4) The following orthodontic services will be paid at the <u>60% benefit level</u>:

Minor treatment for tooth guidance.

Minor treatment to control harmful habits.

Interceptive orthodontic treatment.

Comprehensive orthodontic treatment.

Treatment of an atypical or extended skeletal case.

Post-treatment stabilization.

(5) <u>Separate lifetime maximum of $1,500 per each enrollee:</u>
Orthodontic services for dependents up to age 25, if dependent is a full-time student; for enrolled employee and employee's spouse (if enrolled), no maximum age.

D. <u>Point Of Service PPO</u>: Bargaining unit members and dependents enrolled in the State Dental Plan may avail themselves of improved benefit levels at no additional cost to the plan by utilizing dental care providers who are members of the "dental point of service PPO." The benefit levels and co-payment levels for specific services are as provided below. Enrolled employees and dependents utilizing dental care providers who are not members of the dental point of service PPO shall be subject to current coverage levels and benefits described in subsections 2 and 3 of this section.

Benefit	Current Level	Point of Service PPO Level
Diagnostic Services (Exams)	100%	100%
Preventive Services	100%	100%
Radiographs	90%	100%
Restorative (Fillings)	90%	100%
Oral Surgery (Extractions)	90%	100%
Endodontics	90%	100%
Periodontics	90%	100%
Other Oral Surgery	90%	90%
Adjunctive Periodontic	90%	90%
Crowns	90%	90%
Prosthodontics Repairs	50%	100%
Fixed Bridgework	50%	70%
Partial Dentures	50%	70%
Full Dentures	50%	70%
Orthodontics	60%	75%
Annual Maximum	$1,500	$1,500
Lifetime Orthodontics Limit	$1,500	$1,500

E. Sealants: Application of sealants shall be a covered benefit for permanent molars only, which must be free from restoration or decay at the time of application. Sealants shall be payable only up to the age of 14 years. Payments will be made on a per-tooth basis. No benefit shall be payable on the same tooth within three years following a previous sealant application. The dental plan will pay 50% of the reasonable and customary amount of the sealant application charge, with the employee or covered dependent to pay the remainder of the charge. Under the dental point of service PPO, the plan shall pay 70% of the charge.

F. Dental Maintenance Organization: The Employer shall continue to offer bargaining unit employees the option of voluntarily enrolling in the dental maintenance organization (DMO). The parties understand that the state-approved service area for the DMO program encompasses only certain geographical areas. The DMO will grant a properly completed out-of-area waiver application from a unit member. The parties also understand that all eligible dental services must be provided by a DMO network provider in order for coverage to be in effect (except for emergency treatment for the immediate relief of pain and suffering when the enrollee is more than fifty miles from a participating provider, which will be reimbursed at fifty percent (50%) of the usual, customary and reasonable rate of the non-participating provider).

G. Preventive Dental Plan: A preventive dental plan will continue to be made available as a voluntary option for employees under the flexible benefits plan provided for in Section 8 of this Article.

H. Open Enrollment: An annual open enrollment period shall be provided to all employees in July or August of each year of this Agreement.

Section 7. Vision Care Plan.
Except as provided in section J. below, the Employer will provide a vision care plan paying one hundred percent (100%) of the applicable premium for employees and dependents enrolled in the plan.

A. Participating Providers: Benefits payable under the plan for participating providers will be as follows:

(1) Examination -- payable once in any twelve (12) month period with an employee co-payment of $5.00.

(2) Lenses and frames -- payable once in any twenty-four (24) month period with an employee co-payment of $7.50 for eyeglass lenses and frames and $7.50 for medically necessary contact lenses. However, the benefit interval (for participating providers) shall be once in a 12-month period, if there has been a prescription change. The maximum diameter measure of covered lenses shall be 71 millimeters.

(3) Contact lenses not medically necessary -- the plan will pay a maximum of $90 and the employee shall pay any additional charge of the provider for such lenses. The co-payment provision under B. is not required.

Medically necessary means (1) the member's visual acuity cannot otherwise be corrected to 20/70 in the better eye; or (2) the member has one of the following visual conditions: keratoconus, irregular astigmatism or irregular corneal curvature.

The maximum benefit paid for eyeglass frames to participating providers shall be the provider's costs or $25, whichever is less, plus dispensing fee.

B. Non-Par Providers: Payments for non-participating providers will be as follows:

(1) For vision testing examinations: Once in any twelve (12) month period, the plan will pay 75% of the reasonable and customary charge after it has been reduced by the member's co-payment of $5.00.

(2) For eyeglass lenses: The plan will pay the provider's charge or the amount set forth below, whichever is less.

a. Regular Lenses:
Single Vision.............$13.00/Pair
Bifocal.........................20.00/Pair
Trifocal........................24.00/Pair

b. Contact Lenses:
Medically necessary as defined in subsection C. above ..$96.00/Pair
Not medically necessary...............……………………….. $40.00/Pair

c. Special Lenses:
For covered special lenses (e.g., aphatic, lenticular and aspheric) the plan will pay 50% of the provider's charge for the lenses or 75% of the average covered vision expense benefits paid to participating providers for comparable lenses, whichever is less.

d. Additional charges for plastic lenses:
$ 3.00/pair, plus benefit provided above for covered lenses.

e. Additional charges for tints equal to rose tints:
#1 and #2.. $3.00/pair

f. Additional charges for prism lenses……… ..$2.00/pair
When only one lens is required, the plan will pay one-half of the applicable amount per pair shown above.

(3) For eyeglass frames: The plan will pay the provider's charges or $14.00, whichever is less.

An annual open enrollment period shall be provided to all employees in July or August of each year of this Agreement.

Section 8. Flexible Benefits Plan.
A flexible benefits plan shall be offered to all bargaining unit members during the annual enrollment process and shall be effective the first full pay period in the new fiscal year.

The plan will consist of the group insurance programs with various options available to bargaining unit members. Financial incentives will be paid to employees who select: a catastrophic health plan rather than the standard health plan coverage, a preventive dental coverage rather than the standard state dental plan or reduced life insurance coverage (one times salary or $50,000 rather than two times salary). In addition, members who elect no health care or dental coverage will receive a financial incentive.

Changes in benefit selections may be made by employees each year during the annual enrollment process or when there is a change in family status as defined by the IRS.

Incentives are paid each year and are the same regardless of an employee’s category of coverage. For example, an employee enrolled in employee-only coverage electing the catastrophic health plan for FY05-06 will receive $1,300 as will an employee enrolled in full-family coverage electing the catastrophic health plan.

Incentives to be paid during each fiscal year will be determined in conjunction with the annual rate setting process. The amount of the incentive to be paid to employees selecting the lower-level life insurance coverage is based on an individual's annual salary and the rate per $1,000 of coverage, and therefore may differ from employee to employee. Financial incentives under the flexible benefits plan to employees electing catastrophic health, no health care, and/or reduced life plan will be paid on a biweekly basis. Those choosing the preventive dental plan or no dental plan will receive a lump sum payment.

Section 9. Insurance Premiums While On Layoff And Leave Of Absence.
An employee actually separated by reason of layoff from state employment, on an indefinite basis, may elect to prepay the employee's share of premiums for health, dental, vision and life insurance coverage for the two (2) additional pay periods after layoff, by having such premiums deducted from the paycheck covering the final pay period in pay status. The Employer shall pay the Employer's share of premiums for health, dental and life insurance coverage for two (2) pay periods for any employee who elects this option.

Such coverage for health, dental, vision and life insurance shall continue uninterrupted for the two (2) pay periods referred to above. Election of this option shall not affect the eligibility of the employee to thereafter continue insurance coverage for the remaining period of continuation coverage by directly paying the entire premiums therefor in accordance with current practice.

The maximum continuation coverage period for each insurance program shall be as follows: health -- 3 years; dental -- 18 months; vision care -- 18 months; life -- 1 year.

Permanent full-time employees who do not use the entire two (2) pay periods because of recall, or otherwise returning to state employment on a permanent basis, shall retain this option for full use once in a fiscal (contract) year.

Nothing herein diminishes the rights of a laid-off employee under federal "COBRA" legislation.

Section 10. Group Insurance Premiums For Less Than Full-Time Employees.
Premium payment and eligibility for coverage for permanent intermittent employees shall continue in accordance with current practice.

Employees hired on or after January 1, 2000 who are appointed to a position with a regular work schedule consisting of 40 hours or less per biweekly pay period shall pay fifty percent (50%) of the premium for health, dental and vision insurance. This shall not apply to an employee appointed to a permanent-intermittent position. Eligibility for enrollment shall be in accordance with current contractual provisions.

Employees who have a regular work schedule of 40 hours or less per biweekly pay period who are temporarily placed on a regular work schedule of more than 40 hours per biweekly pay period for a period expected to last six months or more, shall be considered as working a regular work schedule of more than 40 hours for the period of the temporary schedule adjustment.

Section 11. Flexible Compensation Plan.
The Employer's pre-tax dollar deduction program is extended to bargaining unit employees. Under such a program, employee contributions for premiums for health insurance and dental insurance shall be made after FICA calculations, but before income tax withholding calculations are made.

Bargaining unit members shall be offered the option to participate in the State of Michigan dependent care and/or medical spending accounts authorized by, and established by the state in accordance with, current section 125 of the U.S. Internal Revenue Service Code.